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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **EUNICE JOY SARIA-ECHALUSE aka EUNICE SAIZZA** **1429 Hillandale Avenue** **La Habra, CA 90631** **Registered Nurse License No. 756663** Respondent.	Case No. 2013-106 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about July 31, 2009, the Board of Registered Nursing issued Registered Nurse License Number 756663 to Eunice Joy Saria-Echaluse, aka Eunice Saizza (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2012, unless renewed.

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JURISDICTION

3 This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4 Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5 Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISION

6 Section 2761(a)(1) of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

REGULATIONS

7. California Code of Regulations, title 16, section 1443 states:

As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

8. California Code of Regulations, title 16, section 1443.5 states:

> A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COSTS

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CAUSE FOR DISCIPLINE

(Incompetence)

10. Respondent is subject to disciplinary action under section 2761(a)(1) of the Code in that she displayed incompetence in carrying out her usual licensed nursing functions as set forth below.

11. Respondent was employed as a registered nurse at the Town and County Manor (TCM) in Santa Ana, California, on the 3:00 p.m. to 11:00 p.m. shift, from approximately September, 23, 2009 until her termination date on December 17, 2010.

12. Between December 4th and 5th of 2010, Respondent and five other nurses conspired to falsify narcotic count sheets for two patients in order to hide medication errors made by

Respondent and other registered nurses (RN) and licensed vocational nurses (LVN) working at TCM.

13. On December 8, 2010, LVN Candel, was having a supervisory review with the Assistant Director of Nursing (ADON). During this meeting, Candel, LVN gave a narcotic count sheet to the ADON for Patient #1, wherein her signature had been forged on the document. The ADON immediately began investigating the alleged forgery and interviewing all of the nurses whose names appeared on the narcotic count sheet. This investigation revealed an attempted cover up of medication errors involving two patients.

Patient #1

14. On December 1, 2010, female Patient #1's physician ordered that she be given two 15 mg tablets of morphine sulfate twice a day at 6:00 a.m. and at 2:00 p.m. and an additional one tablet as needed for pain. The nursing staff at TCM administered only one 15 mg tablet to the patient at 6:00 a.m. and 2:00 p.m. instead of the ordered two tablets. This resulted in the patient being under-dosed on six occasions and with six extra tablets of morphine sulfate left on the medication cart. There is no evidence that any employee at TCM diverted the narcotics.

15. At approximately 11:00 p.m. on December 4, 2010, Mark Go, RN informed Respondent that there were drug discrepancies involving Patient #1's morphine sulfate order. Three nurses, Mark, RN., Rommel, LVN and Respondent, compared the narcotic count sheet and the physician's orders and discovered that Patient #1 had received only one tablet of morphine instead of the two tablets ordered by her physician on six occasions. It appeared that several nurses were involved in the medication errors. Respondent, Mark, RN, and Rommel, LVN agreed to "fix" the errors by making a substitute narcotic count sheet and then "re-doing" the signatures. Respondent prepared a new false narcotic count sheet, signed her own name on it and signed Rommel, LVN's signature with his approval.

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Patient #2

16. On November 23, 2010, Patient #2's physician ordered one 2.5 mg Marinol[1] tablet to be given to the patient at bedtime. On November 24, 2010, the physician changed the Marinol order to 5 mg at lunch and 5 mg at dinner.

17. On or about December 4, 2010, Respondent discovered that several nurses had been under-dosing Patient #2 by continuing to administer one 2.5 mg. tablet at bedtime and had failed to recognize the physician's change in order resulting in the patient's being under-dosed on about 15 occasions, and an excess of Marinol left on the medication cart that had not been wasted. Respondent immediately told her supervisor Rimmy, RN about the errors. Rimmy, RN recommended that Respondent prepare a new narcotic count sheet. At 11:00 p.m., when the night charge nurse, Mark R.N., came on duty, Respondent told him about the medication errors made on Patient #2 and Rimmy, RN's instructions.

18. At this time, Mark, RN told Respondent about other medication errors made on Patient #1 and that Patient #1 had been given 1 tablet of morphine sulfate instead of 2 tablets as ordered by her physician. Mark, RN asked Respondent to prepare a new narcotic count sheet for Patient #2, which she did and signed.

19. On December 5, 2010, when Respondent came to work she noticed Eliza, LVN and Christine, LVN standing at a medication cart. They asked Respondent to sign a new narcotic count sheet for both Patients #1 and #2. Respondent recognized Christine, LVN's handwriting on the narcotic count sheets and asked them what happened to the ones she had prepared. Respondent was told by Christine, LVN that Mark, RN, said that the count sheets prepared by Respondent did not tally with the medications on hand. Respondent signed the new narcotic logs and she also forged Candel, LVN's signature on the log for Patient #1. The remaining nurses also re-signed the new false narcotic count sheets for both Patients #1 and #2.

[1] Marinol or Dronabinol is used to treat nausea and vomiting caused by chemotherapy in people who have already taken other medications to treat this type of nausea and vomiting without good results.

20. On December 13, 2010, Respondent and five other nurses were suspended from employment at TCM for violating company policy regarding medication errors and falsifying medical records, based upon the instances described above.

21. On December 17, 2010, all six nurses involved in preparing and signing the new false narcotic log sheets were terminated from employment at TCM. The Director of Nursing wrote a letter to Respondent stating the reasons for her termination. It indicated that Respondent made a mistake dosing a narcotic, she did not handle the medication errors per hospital policy, she knowingly engaged in a conspiracy to cover up the dosing errors, she falsified documentation in patients' records, she knowingly signed her name on false documents, and she forged the signature of another employee.

22. TCM Policy regarding medication errors requires a nurse to immediately contact the patient's physician, the DON and nursing supervisor, and complete an incident report. The patient is to be monitored as directed by the physician for any adverse reactions to a medication error. If necessary, the error is to be reported to the consultant pharmacist by the Director. None of these steps were taken by Respondent.

23. When interviewed by an investigator for the Board, Respondent admitted to preparing false narcotic count sheets for Patients #1 and #2, signing false documents, and failing to follow company policy for reporting medication errors.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 756663, issued to Eunice Joy Saria-Echaluse, aka Eunice Saizza;

2. Ordering Eunice Joy Saria-Echaluse, aka Eunice Saizza to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

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3. Taking such other and further action as deemed necessary and proper.

DATED: August 8, 2012

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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